Comments for the Record

United States House of Representatives

Committee on Ways and Means

Subcommittee on Oversight

Hearing on the Tax Ramifications of the President's Health Care Law

Tuesday, March 5, 2013, 11:00 AM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Boustany and Ranking Member Lewis, thank you for the opportunity to submit my comments on this topic. We must note that because the law is actually part of the U.S. Code, it is time to quit identifying it only with the President. It was used as an election issue in 2012 and the results speak for themselves. It is now time to tone down the rhetoric, especially given the electoral composition of the Senate and the resistance by both parties to end the filibuster.

The main issue remaining from last year's Supreme Court ruling is the expansion of Medicaid rolls and the opposition in some states to doing so. While that has seemed to be just posturing in some states, it may lead to the need to federalize the entire Medicaid program, which might occur as part of a comprehensive tax reform, such as the one suggested by the Center.

We believed at the time that opposition to the Law had nothing to do with mandates, the Commerce Clause or Medicaid funding. The real reason conservative major donors don't like the law is the funding mechanism for much of reform. These donors were not successful in court or at the ballot box, so the *American Taxpayer Relief Act of 2012* went into full force without stopping those provisions of the *Affordable Care Act* they objected to. These donors were writing checks because of provisions creating additional taxes on un-earned income that fix Medicare Part A funding and fund other health care reform, essentially turning the Hospital Insurance Tax into a Value Added Tax with an exemption on profits paid to the 98%. Fighting for repeal on this basis, however, would only be politically unpopular.

There is now no reason to repeal the ACA unless the new funding on high income earners is replaced by a broader consumption tax. As we stated in March to the Subcommittee on Health:

> Note that whenever this tax applies to those whose holding operate in less than a perfectly competitive market, in other words to most commerce in 21st century America, the costs will likely be passed to the consumer and it would be more honest to simply enact a Value Added Tax or VAT-like Net Business Receipts Tax (which is proposed below).

Our prior testimony on the adequacy of mandates is as applicable now as it was in March 2012, if not more so. We believe that the stock market priced in repeal and may react negatively to the prospect of guaranteed issue and community rating. The Committee ignores these predictions at their own peril. These impacts, which are outside the scope of the testimony of government witnesses, will likely negate many of the new provisions of the *ACA*. As we stated previously:

> We will now return to the question of the adequacy of mandates. The key issue for the future of health care consolidation is the impact of pre-existing condition reforms on the market for health insurance. Mandates under the *Affordable Care Act (ACA)* may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether for constitutional reasons.
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> If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.
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> In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support, as proposed by Chairman Ryan, also will not work if the *ACA* is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.
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> Resorting to single-payer catastrophic insurance with health savings accounts (another Republican proposal) would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.
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> Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related. For example, Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so (we) will confine (our) remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

If cost savings under an NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed. The ability to exercise market power, with a requirement that services provided in lieu of public services be superior, will improve the quality of patient care.

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Employer provided health care will also reverse the trend toward market consolidation among providers. The extent to which firms hire doctors as staff and seek provider relationships with providers of hospital and specialty care is the extent to which the forces of consolidation are overcome by buyers with enough market power to insist on alternatives, with better care among the criteria for provider selection.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

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